CASE AND COMMENT: HOUSE OFFICERS

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CASE

The patient, a veteran of the U.S. Army, was treated at a federal teaching hospital in October 1986 for a severely impacted left mandibular third molar by a first year dental house officer completing the second month of an initial surgical rotation. The extraction was undertaken without supervision and with no one else in attendance. Due to the degree of impaction, the tooth was sectioned with a power drill and then removed in pieces. A permanent lingual nerve injury, possibly the result of transection, ensued. The patient suffered chronic numbness, permanent paresthesias, and difficulty speaking.

In court, the patient-plaintiff argued that the provider's nearly complete lack of experience in performing a relatively delicate surgical procedure, without supervision, provided a basis for concluding that the cause of the nerve injury in this case was negligence rather than an anomalous location of the nerve.[1] The U.S. District Court judge agreed with this contention, construing certain expert evidence as sufficient to establish a prima facie case for the plaintiff and thereby shifting to the defendant-United States the burden of explaining the manner of the nerve injury. Ultimately, the court determined that liability had been proven when defense efforts in the latter regard were adjudged insufficient.

Initially, the judge noted the testimony of one defense expert that the surgical procedure in question, when performed with requisite care and skill, would be complicated by lingual nerve severance only in those extraordinarily rare cases when the nerve was anomalously positioned so that its injury was literally unavoidable. Further, given the invisibility of the nerve on routine x-rays and its intimate approximation to the third molar, this expert conceded that a third molar extraction is always a particularly sensitive procedure requiring skill at every step and surgery "... you want to have ... done by the most experienced or able doctor possible."

The judge referenced an article from the dental literature, also offered as evidence by the defense, regarding a survey of fellows in the American Association of Maxillofacial Surgery that encompassed third molar surgery performed on 367,170 patients during a five-year period.[2] Impairment of the lingual nerve was reported in 209 cases, one in every 1,756 extractions (less than 0.1 percent). There were 27 instances (less than 0.01 percent) of severe, permanent nerve injury similar to that experienced by the plaintiff. The judge considered this evidence in light of another defense expert's estimate that the rate in the general population for anomalously located lingual nerves is between 0.25 and 0.50 percent. The judge concluded that the survey established either that this estimated rate for the anomaly was too high or that the complication rate, when the procedure is performed by experienced dental surgeons, is so low that nerve injury is usually avoided even when the structure is anomalously located.

The judge, however, was careful in his opinion to stipulate that he was not permitting the establishment of a prima facie case for the plaintiff premised upon statistics alone. He deemed it a "critical additional fact" that the surgery in this case, requiring great care and skill, was in fact performed by a resident trainee with virtually no surgical experience and without the direction and control of a supervising experienced surgeon.

Lastly, the judge was careful to delineate the limited procedural effect of his basic holding, that the establishment of a prima facie case for the plaintiff merely necessitated that the defendant come forward and provide evidence of a satisfactory explanation for the occurrence of this patient's injury. An operative report had not been dictated. Handwritten notes by the house officer from the time of the procedure were

limited, and the resident testified at trial that, although he recalled no details of the procedure in fact performed, he assumed that he had performed the extraction in the manner he had been taught during dental school.

COMMENT

Traditionally, the fully trained, skilled and experienced physician in private practice has been considered by the law as a model of the independent contractor, an actor on the legal stage who is solely and personally responsible for his mistakes or misdeeds. Only relatively recently, and under special circumstances, has the law permitted the vicarious imposition upon others' shoulders of liability for the negligent practice of an independent, fully trained physician.[3]

In contrast, house officers are trainees-in-residence and lack training, skill, and experience by definition. They are incapable of independent practice, and the law has treated them accordingly.

In some jurisdictions, graduate trainees receive no license to practice or are issued licenses limited for training purposes alone.

For more than one hundred years, case law has permitted the mistakes or misdeeds of interns and residents to occasion the imposition of vicarious liability.[4] Generally, house officers are considered employees of the institutions where they train, and their negligent acts are legally considered equivalent to those of any other type of hospital employee. At present, only a single question appears to persist, whether vicarious liability for house officers should rest solely with the hospital or be shifted to responsible supervising staff physicians, those most directly in control of trainees.[5]

The case presented is instructive because it clearly reveals how harsh the approach of the courts can be when deliberating severe injuries to patients at the hands of trainees who have proceeded without adequate supervision, direction, or control.

In a surgical context (easily applied to other aspects of medical practice), the occasion of a liability dispute often is the appearance of an inherent complication of some previously provided procedure. The fully trained surgeon, given the extent of skill and experience necessary to attain such a position, is granted many powerful presumptions in court. Among the most difficult facing a plaintiff pursuing legal relief are that surgeons are presumed not to guarantee outcomes and to have rendered standard care. Further, any inherent complications that arise are presumed to have occurred in spite of that standard care. If a plaintiff fails, by direct and positive evidence, to prove a case to the contrary, those presumptions act to relieve the surgeon of liability, theoretically were no evidence offered by the defense.

Within teaching medical facilities, under proper circumstances, house officers are permitted the opportunity to care for patients while duly supervised by fully trained tutors and to borrow, in essence, from the accounts of their supervisors' preexisting, certified skill and experience. Thereby, they may also come to avail themselves in court of those same powerful presumptions granted their tutors should an adverse outcome arise and be the subject of a malpractice claim.

In the absence of those proper circumstances, as occurred in the case reported, not only are the normal presumptions unavailable to the trainee who acts without adequate supervision, but they may be reversed. By such an analysis, the rare complication will be presumed to have been caused by the negligence of the trainee, unless the defense can proffer direct evidence to the contrary, a potentially insurmountable burden.

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Researchers from Harvard University surveyed a representative sample of medical records from all hospitalizations in the state of New York during 1984.[6] Their initial goals were to determine the rate at which those records reflected adverse, i.e., unexpected or undesired, clinical outcomes and the subset rate among all adverse outcomes of those deemed related to substandard medical care.

Overall, the approximate rate of adverse outcomes during hospitalization was four percent, with one percent considered to have resulted from negligent care (a 25 percent subset). In further analyses, the researchers found variations in both rates when their data was stratified according to the teaching status of the hospital. They categorized hospitals as university medical centers, institutions with limited teaching affiliation, and non-teaching hospitals. Given standardization for patient age and DRG case mix, adverse outcomes occurred more frequently at university teaching hospitals, almost twice as often as in non-teaching facilities, but the rate of those events considered to have resulted from negligence was significantly less there (an 11 percent subset) than elsewhere, especially at the affiliate institutions (a 29 percent subset).

Appellate courts are often compelled to resolve civil disputes that involve heated, conflicting issues of social policy. In their deliberations, they are drawn to resolutions that they decide reflect common, current societal expectations. For that purpose, courts occasionally appear attracted to national "standards" promulgated by such organizations as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Current JCAHO standards state that a hospitalized patient will be admitted and ultimately cared for by a fully credentialed member of the medical staff. Further, the participation of house staff in that care should occur only under the appropriate degree of medical staff supervision, in accord with specific written regulations.[7]

In any teaching hospital, the conduct of trainees, their supervisors, and the institution should jointly reflect an awareness that the path to patient safety and sound medical practice, an avenue identical to that of liability risk management, necessitates a persistent level of diligence and circumspection.

REFERENCES

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